NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2021

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The Justice Center's Promise to New Yorkers with Special Needs and Disabilities

OUR VISION

People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety and dignity; and by supporting the dedicated people who provide services.

OUR MISSION

The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

OUR VALUES AND GUIDING PRINCIPLES

Integrity: The Justice Center believes that all people with special needs deserve to be treated with respect and that people's rights should be protected.

Quality: The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

Accountability: The Justice Center understands that accountability to the people we serve and the public is paramount**.**

Education: The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

Collaboration: Safe-guarding people with special needs is a shared responsibility, and the Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

NEW YORK STATE OF OPPORTUNITY. Justice Center for the Protection of People with Special Needs

KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

February 16, 2022

To the Governor and Legislature:

I am pleased to provide you with the 2021 Annual Report of the Justice Center for the Protection of People with Special Needs, as required by Executive Law § 560 and Correction Law § 401-a (2). This report summarizes the agency's activities and accomplishments from January 1, 2021 through December 31, 2021. It includes, but is not limited to, the following statistics and information:

- Number of reports received by the Vulnerable Persons' Central Register (VPCR)
- Results of investigations by types of facilities and programs
- Types of corrective actions taken
- Results of the review of patterns and trends in the reporting of and response to reportable incidents, and recommendations for appropriate preventative and corrective actions
- Efforts undertaken to provide training
- Description of the Justice Center's efforts to monitor the state's compliance with the statutory requirements for the provision of mental health services to incarcerated individuals, including those with serious mental illness in segregated confinement

Additional information about the Justice Center can be found on the agency's website at www.justicecenter.ny.gov.

Respectfully submitted,

Denise M. Miranda, Esq.

Executive Director

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I. EXECUTIVE SUMMARY

The Justice Center for the Protection of People with Special Needs continues to hone the tools it uses to protect the health, safety, and dignity of all people with special needs and disabilities. This is done in a variety of ways including: developing abuse prevention tools, providing education to stakeholders on Justice Center operations, and ensuring high quality investigation of all allegations of abuse and neglect.

To achieve its mission, the Justice Center standardized the state's systems for incident reporting, investigations, disciplinary processes for state employees, corrective and preventive actions and pre-employment background checks. The outcome of these activities is outlined in this report. In addition, the Justice Center has implemented several strategic initiatives to improve agency functions and address concerns with agency stakeholders in order to ensure we are protecting New York's most vulnerable citizens while also supporting the dedicated people who care for them.

II. HISTORY AND JURISDICTION

The Protection of People with Special Needs Act (Ch. 501, L. 2012) established the Justice Center for the Protection of People with Special Needs as an executive agency responsible for protecting the safety and well-being of the approximately one million adults and children who, due to physical or cognitive disabilities, or the need for services or placement, are receiving care from certain facilities or provider agencies that are licensed, operated, or certified within the systems of six state oversight agencies. These agencies include:

- Office for People with Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Addiction Services and Supports (OASAS)
- Office of Children and Family Services (OCFS) (State-operated programs/facilities and certain residential programs)
- Department of Health (DOH) (Summer camps and adult homes that meet certain criteria)
- State Education Department (SED) (Certified residential schools and programs)

(Please see: Appendix A for additional information on the Justice Center's jurisdiction.)

The agency, which became operational on June 30, 2013, serves as the state's central repository for all reports of allegations of abuse, neglect and significant incidents involving vulnerable individuals as defined in Social Services Law (SSL) § 488(1). The Justice Center maintains a case management system that tracks all reported cases of abuse and neglect to resolution, ensures all allegations are fully investigated, and makes final legal determinations on all allegations. The Justice Center's Special Prosecutor/Inspector General works with county district attorneys to prosecute allegations that are criminal in nature. The Justice Center's Individual and Family Support Unit provides guidance, information, and support to victims and their families throughout the investigative process.

Through its oversight and monitoring activities, the Justice Center identifies durable corrective and preventive actions to address the conditions that cause or contribute to the occurrence of abuse and neglect. In consultation with its Advisory Council, the Justice Center also works collaboratively with a broad array of stakeholders to promote

prevention strategies and to develop guidance and tools to help facilities and programs better protect people receiving services. (Please see: Appendix D for information about the composition of the Advisory Council.)

The Justice Center operates with a staff of 425 committed professionals. The agency's front-line staff, which includes call center representatives, investigators, attorneys and individual and family support advocates have collectively accumulated decades of experience working with special populations at state oversight and private provider agencies and in other service systems prior to joining the Justice Center.

The activities and accomplishments highlighted in this report reflect the work of the Justice Center in partnership with state oversight agencies, non-profit provider agencies and individuals and families who, together, are effectively promoting positive changes that have resulted in a system of care where people who receive services are treated with dignity and respect and those who provide services and supports are valued and supported.

III. 2021 HIGHLIGHTS AND INITIATIVES

❖ *COVID-19 Assistance*

Like many state agencies, the Justice Center provided assistance for the following initiatives, helping New Yorkers during the COVID-19 pandemic:

- Emergency Rental Assistance Program – The Emergency Rental Assistance Program (ERAP) expedited the allocation and distribution of Emergency Rental Assistance federal funds. Justice Center staff filled all levels of staffing needs including top leadership, coaching support and application processing. During the program, which began taking applications in June, State Staff volunteers processed more than 45,000 ERAP applications totaling approximately $200 million. In addition, staff reviewed almost 10,000 applications for the Landlord Rental Assistance Program (LRAP) totaling around $90 million.

- State Liquor Authority COVID Compliance - Justice Center staff continued to support the State Liquor Authority's COVID-19 Compliance Initiative that was established the year prior. Staff members covered shifts seven days a week from 4pm to midnight, assisting in the observation of more than 16,000 establishments. The program completed in mid-May.

- Department of Health - Justice Center staff assisted with the Department of Health's (DOH) Vaccine Initiative at the University at Albany. Staff worked 12-hour shifts for nearly three months to help cover a seven-day per week operation to vaccinate as many New Yorkers as possible.

- The Justice Center continues to serve as a first point of contact for OPWDD providers reporting COVID-19 cases. The Justice Center has received approximately 23,000 calls under this initiative since March of 2020.

❖ *New Prevention Materials Released*

The Justice Center recognizes the importance of working to prevent abuse and neglect from happening in the settings under the agency's jurisdiction. The Justice Center produces a series of toolkits called the "Spotlight on Prevention", which is updated on a regular basis.

The Justice Center uses data compiled in the *Vulnerable Persons' Central Register (VPCR)* to do trend analysis for issues that may be putting people with special needs at risk. In 2021, the Justice Center developed the new toolkit *"Best Practices for Body Checks"*. This toolkit provides information and resources to support the safety of people who are unable or require assistance to identify and report illness, injury, abuse, or neglect. Case studies are included to assist in provider agency training about the importance of body checks. Guidance is also provided on documenting findings and seeking medical assistance when required.

Several other toolkits are available on the Justice Center's website. Other toolkits developed based on trend and data analysis include: *Dangers of Being Left Unattended in Vehicles, Dangers of Caregiver Fatigue, Reducing the Use of Restraints, Maintaining Professional Boundaries, Securing Wheelchairs in Vehicles,* and *Preventing Intestinal Obstructions.*

Finally, the Justice Center took one of our most popular Spotlight toolkits, "Maintaining Professional Boundaries", and created an online training for agency staff. Professional Boundaries are the framework within which the relationship between the service provider and the individual receiving services occurs. This framework ensures that the relationship is professional and safe for the individual and sets parameters for services. Professional Boundaries along with the Justice Center Code of Conduct are critical tools for preventing abuse and neglect. Justice Center staff have been providing in-person training on this critical topic to state oversight and provider agency staff. In response to increasing demand for this training, the Justice Center developed an online, interactive training that can be viewed by individuals or can be used to facilitate a group discussion.

❖ *Incident Management Unit Created*

The Justice Center created the Incident Management Unit (IMU) in 2021 to provide separation between the classification and investigation functions of the agency. The development of the unit streamlines the intake and classification process flow, allows for collaborative trainings and quality assurance efforts, centralizes reporting, and allows for centralized communications with internal and external stakeholders.

❖ *Diversity, Equity, and Inclusion Strategy*

The Justice Center leadership team attended a Diversity, Equity, and Inclusion Strategy session in October. The session centered around understanding the complex dynamics

underlying diversity challenges and opportunities within the agency. The course focused on improving engagement, counteracting unconscious bias, and fostering an inclusive climate. The leadership team created action plans that will be implemented by Leadership and the Justice Center's Anti-Racism Workgroup.

❖ *Category 2 Notification Expansion*

New legislation passed in 2021 expanded the requirement for Category 2 notifications for OPWDD providers. The new process extends the required notification to any additional OPWDD providers at which an individual is actively employed or volunteering other than the employer where the Category 2 occurred. The Justice Center created a workgroup to assess the current process and identify ways to meet the new legislative requirement. The workgroup developed a new process and completed all necessary training ahead of the December 2021 implementation date.

❖ *Investigation Strategy Memo*

The Justice Center began issuing an investigation strategy memo for cases delegated to a State Oversight Agency for investigation beginning on February 1, 2021. The memo includes information about the required components of an investigation and the specific evidence that must be included when it is submitted back to the Justice Center for review. The memo also serves to increase communication between the agencies conducting delegated investigations and the Justice Center. As a result of these strategy memos the Justice Center has already seen a decrease in quality issues related to delegated investigations.

IV. WORKFORCE AND STAKEHOLDER OUTREACH

The Justice Center makes protecting the rights of the dedicated workers who provide direct care to vulnerable individuals a top priority. In addition, the agency recognizes its responsibility in supporting victims in an investigation. As such, the Justice Center has developed several initiatives to support the workforce, providers, families, and other stakeholders.

❖ *Individual and Family Support*

The Justice Center provides guidance and support to victims of abuse or neglect, their families, personal representatives and guardians throughout the course of an investigation. Nearly 16,000 individuals and family members have contacted advocates for assistance since 2013. In 2021, more than 2,750 individuals and family members were provided with advocacy support.

Advocates provide information about the reporting and investigative process, case status updates and records access. In 2021, the Justice Center provided assistance to individuals and families regarding records access nearly 600 times.

In addition, Justice Center advocates accompany victims to interviews or court proceedings. In 2021, advocates provided victim and witness accompaniment in Justice Center-led investigations on more than 315 occasions. Justice Center advocates also coordinate questions or concerns involving State Oversight Agencies.

The Justice Center attends conferences and informational events throughout the state, offering materials and answering questions about the Justice Center. Advocates presented at or participated in 11 such events in 2021. The expanded use of technology to conduct virtual conference appearances has allowed for a larger number of individuals to participate.

Over the past year, the Justice Center provided valuable information and education on the investigative process and the role of the advocate to external stakeholders by offering multiple virtual family engagement sessions with more than 500 people participating.

In addition to these responsibilities, the Justice Center has been a leader in practicing and advancing trauma-informed practices and has actively participated as part of the Trauma Champions Collaborative.

❖ *Champion and Code of Conduct Awards*

The Justice Center understands the importance of recognizing individuals who demonstrate a commitment to people with special needs. The agency has created two awards: the Justice Center Champion Award and the Justice Center Code of Conduct Award. This year was the fifth consecutive annual award presentation.

The Champion Award honors New Yorkers who have displayed exemplary dedication to people with special needs. The honorees in 2021 included a parent and longtime advocate who has become a leader in legislative advocacy, a Surrogate Decision-Making Committee volunteer who has served for more than 15 years and been panel chair in more than 140 hearings, a former BOCES employee who has dedicated his time in retirement to helping the Technology-Related Assistance for Individuals with Disabilities (TRAID) program, and an attorney for the Mental Hygiene Legal Service who has worked with the Justice Center on countless Surrogate Decision-Making Committee cases.

The Justice Center appreciates the importance of honoring staff at provider agencies who display a strong commitment to the Code of Conduct and serve as an inspiration to their colleagues. The individuals who serve in these roles have always been essential workers, but their impact has been magnified at a time when the pandemic limited interaction with people outside of facilities. In total, seven individuals were presented with the Justice Centers Code of Conduct award. Each exemplifies the highest standard of direct care and shows the state the difference one person can make in someone else's life.

As part of the Justice Center's presentation of the Code of Conduct Awards, the agency produced a video featuring messages of gratitude and appreciation from the Commissioners of several State Oversight Agencies as well as photos of direct care workers. Executive Director Miranda also read portions of a proclamation that declared part of September to be Direct Support Professionals Recognition Week.

❖ *Stakeholder Briefings*

The Justice Center spends considerable time engaging with provider agencies, the direct care workforce, family members, local government, and other interested stakeholders. The agency understands that partnerships formed with these stakeholders are crucial to the success of the mission of the Justice Center. In 2021, the agency conducted more than 50 presentations, the majority of which were to provider agencies under the Justice Center's jurisdiction as well as their staff. The Justice Center also conducted outreach presentations to local government agencies, attorneys, and people receiving services and their families.

❖ *Advisory Council*

The Justice Center's Advisory Council provides guidance to the agency in the development of policies, programs and regulations. Members include service providers, people who have or are currently receiving services, their family members and advocates. At least half of the members must be individuals, or parents or relatives of individuals, who are receiving or have received services from programs under Justice Center jurisdiction. Advisory Council members are appointed by the Governor, with the advice and consent of the Senate, for three-year terms. The Council meets quarterly.

Advisory Council members serve on one of four committees: legislation and regulations, abuse prevention, workforce issues, and investigator and law enforcement training. Each committee provides valuable insight to the Justice Center that is used to craft policies, procedures and outreach.

V. TRAINING AND SAFETY IMPROVEMENTS

The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems changes. That is why the agency has made a substantial investment in training of both internal staff and external stakeholders. The Justice Center offers a variety of training and support materials to ensure the health, safety, and dignity of people with special needs. These include: Forensic Interviewing Best Practices for Vulnerable Populations, Code of Conduct and State Oversight Agency Restraint Training.

❖ *State Oversight Agency Collaborative Trainings*

The Justice Center is mandated to provide investigation training to State Oversight and provider agency staff. In 2021, the agency adapted the two-day, in-person Introduction to Investigative Techniques Training into three partial-day, on-line trainings. This move allowed the Justice Center to offer the training more frequently and the ability to reach larger audiences, while minimizing travel and lodging costs. In 2021, 5 sessions were held which were attended by 450 investigators. The agency also acted on a recommendation from its Advisory Council and started an annual on-line series of trainings on investigative topics for State Oversight and provider agency investigators. The plan is to host three to four trainings per year. This year, the Justice Center provided training on the new strategy memo; sepsis and considerations when investigating allegations of neglect; to more than 300 State Oversight and provider agency staff.

❖ *Justice Center In-Service Training*

As part of the Justice Center's commitment to continuous improvement, the agency offers an annual in-service training for all investigators and members of other business units. This year's in-service, Renew & Refresh, was a three-day virtual event. The training included the following topics:

- Diagnoses that impact individuals receiving services in New York State, including a review of the five most fatal diagnoses for individuals with development and intellectual disabilities
- Common mental health diagnoses and what investigators need to know
- Autism from the Center for Autism Spectrum Disorders.
- The best use of photographic evidence and social media in investigations
- Trends in administrative appeals decisions
- A review of the Marihuana Regulation and Taxation Act and its potential impact on Justice Center investigations
- The impact of implicit bias in the courtroom.

In total, more than 260 Justice Center staff attended the training.

❖ *Safety Alert*

The Justice Center regularly evaluates case data for trends that can ultimately guide needed safety improvements. Recently, the agency requested that OPWDD issue an alert and guidance to the field regarding the importance of following manufacturer instructions on Hoyer lifts after noticing a series of injuries related to their use. At OPWDD's request, the Justice Center sent two years of data on incidents involving these specific lifts in OPWDD settings. OPWDD subsequently issued a Health and Safety Alert to the field titled "Important Information About the Use of Mechanical Lifts". The alert provides recommendations on implementing policies and procedures in keeping with NYS Safe Patient Handling Law and the FDA that include safe mechanical lift operation, equipment maintenance, staff training, and periodic review and revision of the policies and procedures.

VI. ABUSE PREVENTION AND QUALITY IMPROVEMENT

One of the missions of the Justice Center is to develop tools to help prevent mistreatment of individuals with special needs. There are several ways the agency works toward the *prevention* of abuse and neglect. Examples include pre-employment checks to ensure the safety of both individuals receiving services and the workforce, data analysis to look for trends and issue guidance on how to stop practices that might endanger vulnerable populations, and quality improvement reviews. All of the Justice Center's actions encourage provider agencies, people receiving services and staff members to take a proactive approach to establishing safe, supportive and abuse-free environments.

i. Prevention

A. Criminal Background Checks

The Justice Center reviews and evaluates the criminal history of all prospective employees or volunteers applying for jobs at provider agencies under its jurisdiction and advises about the individual's suitability for employment. This comprehensive review provides a safety net for individuals receiving services while at the same time mitigates risk for employers and the dedicated workforce.

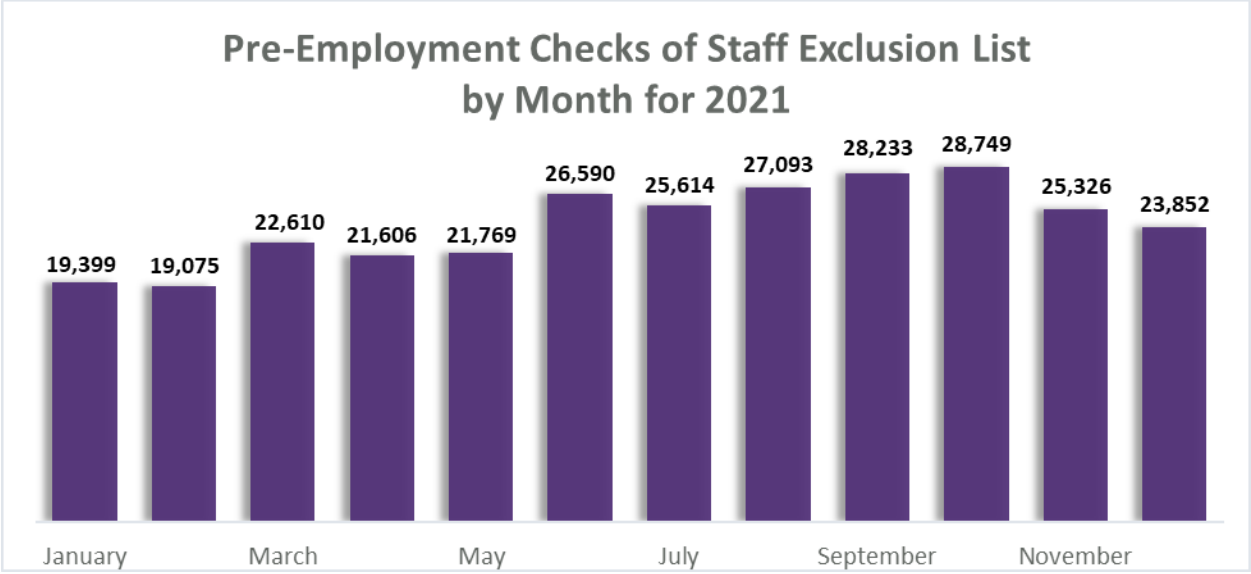
Criminal Background Checks Fingerprints Processed & Applicants Reviewed

State Oversight Agency	2021
Total Fingerprints Processed	**87,003**
OPWDD	58,823
OMH	19,535
OCFS	8,645
Total Applicants Reviewed	**8,677**
Denied Approval for Employment Consideration	**270**
OPWDD	163
OMH	69
OCFS	38

B. Staff Exclusion List

Another tool used to prevent those who have a history of abusing vulnerable populations from continuing to work with and have access to individuals receiving services is the Justice Center's *Staff Exclusion List (SEL)*. All subjects substantiated for Category One (definition see pg. 23) conduct, which includes serious or repeated acts of abuse or neglect, or two substantiated Category Two findings within three years, are placed on the SEL. Placement on the SEL bars an individual from working in all settings under the Justice Center's jurisdiction forever.

Provider agencies under the Justice Center's jurisdiction, as well as other providers identified in statute, are required to check the SEL before hiring someone who will have regular and substantial contact with an individual with special needs. Providers have been notified through the SEL check process nearly 250 times since 2014 that an applicant was on or was pending placement on the SEL. This means individuals who have been substantiated for serious acts of abuse and neglect were stopped from being hired into settings where they would have regular and substantial contact with vulnerable people again.



The total number of individuals on the SEL at the end of 2021 was 838. That is an increase of 79 from 2020.

C. Corrective Action Plans

Following a substantiated allegation of abuse or neglect, corrective action plans are developed to address any concerns. The plan provides the road map to improve the circumstances or conditions that contributed to the incident. The development of this plan also provides an opportunity to look for additional areas in need of improvement at a program or agency. In 2021, the Justice Center issued guidance and best practices for provider agencies to assist them in the implementation of corrective action plans. The toolkit includes a list of questions for agencies to consider during the lifecycle of an incident, a reference guide for documentation supporting the implementation of corrective actions, and resources for success.

ii. Quality Improvement

The Justice Center has the authority and responsibility to make recommendations on improving the quality of care at facilities under its jurisdiction. This is done through reviews and audits of corrective action plans and can include visits to and inspections of facilities or provider agencies. This important audit function allows the Justice Center to make recommendations to provider agencies so that they can improve quality of care and protect the people they serve from harm.

D. Corrective Action Plan Audits

As part of the Justice Center's oversight and monitoring function, the agency reviews and conducts audits of corrective actions that stem from abuse and neglect cases to ensure facilities and provider agencies are taking the necessary steps to prevent incidents of abuse and neglect in the future. Corrective action plan audits are most often completed after a finding that abuse or neglect was caused by a systemic issue. In 2021, the Justice Center conducted 224 audits of facility and agency corrective action plans which included assessing 1,364 corrective actions and identifying 42 additional findings. Modifications were made during the COVID pandemic to ensure the safety of all individuals receiving services and staff members. Examples of the audits and results are below.

Examples:

Audit #1: Failure to Train All Staff

Narrative: Between November 29, 2019, and December 27, 2021, three corrective action plan audits were conducted on cases involving the failure of a residential service provider to prevent a person receiving services from ingesting harmful substances. The audits repeatedly revealed that the provider agency failed to ensure all staff in the residence, including temporary staff, were trained on the person's treatment plan and supervision requirements.

Result: The Justice Center discussed the provider's continued failure to train all staff with OPWDD and the agency was put on Early Alert Status by OPWDD and monitoring by OWPDD was increased. In November, the provider agency notified the Justice Center, in response to another audit, that the residential director will immediately begin ensuring that all staff receive trainings as required by cross referencing training sign in sheets with staff rosters.

Audit #2: Improper Use of Restraints

Narrative: During the course of a corrective action plan audit of an incident in a psychiatric unit in a hospital, the Justice Center discovered that the hospitals' crisis management policy permitted staff to place a towel over the head of a person being restrained to control the movement of the head. This practice can obstruct a person's airway and cause serious injury or death. At the time of the audit, the hospital had three additional cases involving the deliberate, inappropriate use of restraints.
Result: Upon discovering the crisis management policy, the Justice Center contacted the state oversight agency, OMH, and requested that they provide guidance to the hospital. OMH issued guidance, reminding the hospital that this practice is prohibited by the Joint Commission, and offered assistance in changing this policy.

E. Special Housing Unit (SHU) Monitoring and Audit

The Justice Center oversees compliance with the SHU Exclusion Law and monitors the quality of mental health care provided by the Office of Mental Health (OMH) to people who are incarcerated in state prisons.

The Justice Center reviewed the mental health care provided to incarcerated individuals who are placed in solitary confinement in SHUs in 12 facilities in 2021. In total, the Justice Center completed 436 cell-side and 62 private interviews with incarcerated individuals and referred 56 of those individuals to be evaluated by OMH. The agency also reviewed the quality of mental health care for 169 incarcerated individuals. In addition, the agency reviewed the records of over 197 incarcerated individuals placed in solitary confinement to determine if they received mental health care and assessments in accordance with the requirements of the SHU Exclusion Law. The Justice Center found that seven of the twelve Special Housing Units reviewed were in compliance with the SHU Exclusion Law. A summary of the Justice Center's findings through 2019 can be found on the agency website.

The Justice Center conducted a review of the quality of mental health treatment, programming, informational reports and disciplinary sanctions received by 330 incarcerated individuals who were housed in an Intermediate Care Program (ICP) between November 2017 to July 2019. The ICP is intended to be a therapeutic community providing rehabilitative services to individuals who are incarcerated and are unable to function in general population because of their mental illness. The goal of the program is to improve a person's ability to function through programming and treatment so that they may return to general population and the community.

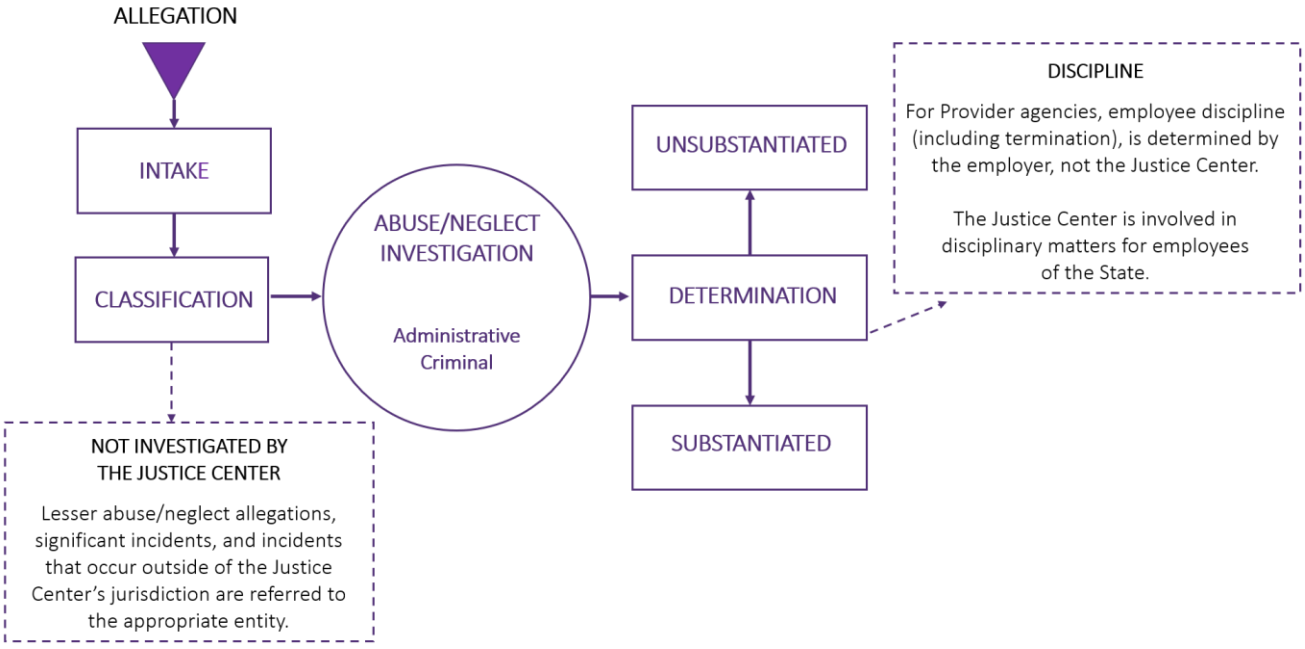
The Justice Center found that ICPs, when fully staffed and when OMH and DOCCS staff collaborate, provide a therapeutic environment for individuals who are incarcerated and diagnosed with a serious mental illness. However, there were significant variations in the frequency of disciplinary actions at ICPs, including the type of sanctions imposed, and the length of time incarcerated individuals in the ICP received a segregated confinement sanction.

In 2021, the Justice Center also began preparations to implement provisions in the Human Alternatives to Long-Term Solitary Confinement Act. The legislation will increase the agency's oversight responsibilities in 2022 to include all New York State prisons. It also expands the areas the Justice Center must assess in order to determine compliance. In 2021, the agency began meeting with OMH, Department of Corrections and Community Supervision, and advocates about implementation. Site visit policies are under evaluation for any needed revision.

VII. INCIDENT MANAGEMENT

The Justice Center investigates, reviews and makes findings in allegations of abuse and/or neglect by staff against individuals who receive services. "Staff" can include employees, volunteers, interns, consultants or contractors of a facility or provider agency. An investigation by the Justice Center is launched after a report is made to the Vulnerable Persons' Central Register (VPCR). That complaint then works its way through an investigatory process that ultimately ends in a substantiated or unsubstantiated finding. Allegations can also result in criminal prosecution. Every allegation classified as possible abuse or neglect is investigated to conclusion. Below is a chart that outlines the process by which a report is handled at the Justice Center.

❖ Process of a Justice Center Investigation



i. Intake

Anyone, including a parent or guardian, advocate, or individual receiving services can make a report to the VPCR when they have knowledge or have reason to believe that a person receiving services has been abused, neglected or mistreated. Some people are required by law to report to the VPCR. These "mandated reporters" include provider agency staff and human services professionals who, by nature of their job, must report allegations of abuse or neglect.

Call center representatives are available 24 hours a day, seven days a week, 365 days a year. The number to contact the toll-free hotline to make a report is **855-373-2122.** A web-based reporting form and a mobile application are also available for use.

The call center representative will first assess whether an emergency responder is necessary and/or if the person receiving services is in danger or needs immediate assistance. If that is the case, the caller is instructed to hang up and call 9-1-1. The reporter should then call back once the emergency is over to file the report. If no emergency exists, the call center representative will collect information from the reporter and assign an incident number.

ii. Classification

Once the allegation is assigned an incident number, it is then classified into one of the following categories: abuse/neglect, death, significant incident or non-NYJC.

- **Abuse**
  - Physical: intentional contact (hitting, kicking, shoving, etc.), corporal punishment, injury which cannot be explained and is suspicious due to extent or location, the number of injuries at one time or the frequency over time
  - Psychological: taunting, name calling, using threatening words or gestures
  - Sexual: includes inappropriate touching, sexual assault, and sexual contact with a person incapable of consent
  - Deliberate misuse of restraint: use of these interventions with excessive force, as a punishment or for the convenience of staff
  - Controlled substances: using, administering or providing any controlled substance contrary to the law
  - Aversive conditioning: unpleasant physical stimulus used to modify behavior without person-specific legal authorization.

- **Neglect**
  - Any breach of a direct care employee's duty which includes action, inaction or lack of attention on the part of the employee that results in or is likely to result in physical injury or serious impairment to the person's physical, mental or emotional condition

- **Death**
  - The Protection of People with Special Needs Act requires certain deaths be reported to the Justice Center. These include the death of an individual receiving services from a residential facility or program that is licensed, certified or operated by OPWDD, OCFS, OMH and OASAS

- **Significant Incident**
  - Incident other than an incident of abuse or neglect that, because of its severity or the sensitivity of the situation, may result in or has the reasonably foreseeable potential to result in harm to the health, safety or welfare of a person receiving services. Examples include conduct between persons receiving services and conduct of an employee that is inconsistent with an individual's treatment plan

- **Non-NYJC Incident**
  - The nature of the incident is not reportable to the Justice Center because the incident is not a reportable incident or because it did not occur at a provider over which the Justice Center has jurisdiction. These can vary widely and may include concerns about a provider, or complaints about food. Cases that require follow-up are referred to the appropriate State Oversight Agency.

- **Not an Incident**
  - Calls that do not allege any type of incident but instead may be general inquiries or incorrectly routed calls. The Justice Center will refer to a relevant agency or entity if available.

Reports Made to the Justice Center	2021
Grand Total	**90,160**
Abuse and Neglect	11,766
Death	1,740
Significant Incident	24,521
Non-NY JC Incident	40,780
Not an Incident	11,353

- **Three-Business Day Review of Incidents**

  The Justice Center has implemented a review process for allegations where appropriate classification of an incident may initially be difficult to accurately determine. The three-business day assessment allows the agency to conduct a preliminary review of allegations lacking specificity by obtaining additional information from the facility or provider agency. This involves the collection of a minimum amount of documentation to accurately classify and assign a case. This additional short step allows classification to be better informed and therefore a more accurate incident classification and a better use of investigative resources.

  The three-business day assessment is available to all OPWDD, OMH, OCFS, and OASAS providers.

Three-Business Day Review of Incidents – 2021										
Classification	OPWDD		OMH		OASAS		OCFS		Grand Total	
	#	%	#	%	#	%	#	%	#	%
Remained JC A/N	524	36%	425	26%	60	49%	215	38%	**1,224**	**33%**
Reassigned to SOA Led A/N	179	12%	113	7%	0	0%	142	25%	**434**	**12%**
Reclassified (SI or Non)	743	51%	1,072	67%	63	51%	208	37%	**2,086**	**56%**

iii. Criminal vs. Administrative

Once a case is classified as abuse or neglect, that case is next characterized as either criminal or administrative.

- **Criminal Cases**

  The Justice Center's Special Prosecutor works with county district attorneys to bring criminal charges in cases that allege that a crime has occurred against an individual receiving services by an employee of a facility or provider agency. The Justice Center notifies district attorneys of *all* allegations of abuse and neglect. Cases involving potential criminal charges can be investigated by the Justice Center, the local police, or both.

  In 2021, 55 arrests were made in connection to Justice Center cases.

  This number is lower than prior years. The NYS Court of Appeals issued a decision in 2021 that limited the agency's ability to prosecute cases independently. The Justice Center's Special Prosecutor maintains the statutory duty to cooperate with and offer assistance to the local district attorneys, and can prosecute cases with the consent of the local district attorney. The agency also assists local law enforcement in investigating allegations of abuse and neglect.

  While a criminal case is being investigated and prosecuted, the same case is also investigated through the Justice Center administrative investigation process.

- **Administrative Cases**

  The first step in the administrative investigation of allegations of abuse and/or neglect is appropriate classification and assignment for investigation. The Justice Center investigates allegations in

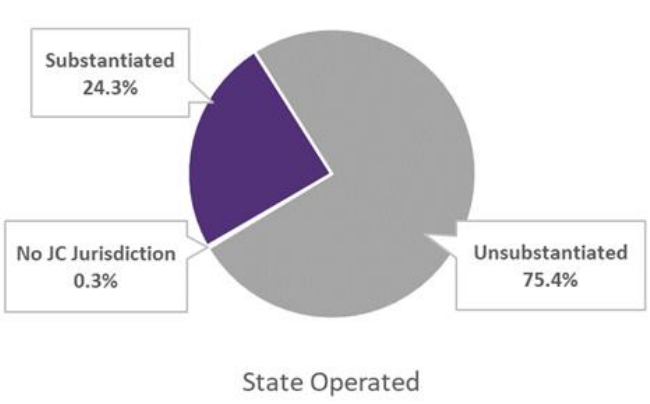
state-operated programs as well as the most serious allegations in non-state operated settings. Less serious allegations of abuse and neglect in non-state operated settings are delegated to the State Oversight Agency for investigation, which in turn may delegate to the provider. The Justice Center reviews all investigations regardless of which delegate investigative agency conducts them and makes all final determinations regarding whether a case will be substantiated or unsubstantiated. Significant incidents are referred to the appropriate State Oversight Agency for investigation.

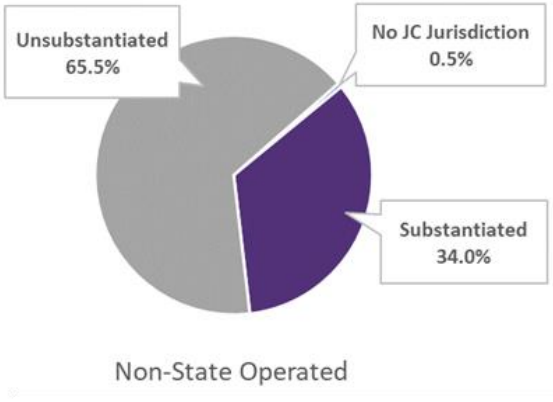
The investigation process proceeds with examination of the evidence and interviews of witnesses, victims and subjects. Witnesses and subjects of Justice Center investigations can have legal counsel or a union representative present when being interviewed, unless an applicable union contract, or Collective Bargaining Agreement, provides differently. Individuals receiving services who are the victim of or witness to abuse and neglect may have a personal representative or an advocate from the Justice Center's Individual and Family Services Unit accompany them during an interview.

iv. Determination

Administrative cases conclude by either being substantiated or un-substantiated. The Justice Center makes the final determination regardless of which agency completed the investigation. The standard of proof for a Justice Center administrative case is a *preponderance of the evidence*. This means a review of the evidence shows the allegation of abuse or neglect was more likely than not to have occurred.

Percentage of Investigation Outcome for Abuse and Neglect Cases in 2021





- **Unsubstantiated**: the case is sealed (not made public and cannot be accessed by future employers) and a letter of determination is

sent to the subject, victim and provider agency letting them know the finding.

- **Substantiated**: the case is classified into one of four categories depending on the severity:
    - **Category 1**: Serious physical abuse, sexual abuse or other severe conduct. Category 1 substantiations place subjects on the Staff Exclusion List (SEL). Subjects on the SEL are banned from working in any setting under the jurisdiction of the Justice Center and remain on the list forever.
    - **Category 2:** Conduct that seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Two Category 2 substantiations within three years will result in placement on the SEL. Category 2 offenses are sealed after five years.
    - **Category 3:** Less serious incidents of abuse or neglect. Reports are sealed after five years.
    - **Category 4:** Incidents of abuse or neglect that are mitigated by systemic conditions at a program or facility that increased the likelihood of such abuse or neglect, such as inadequate training, staffing, or supervision. Category 4 also include instances in which an individual receiving services has suffered abuse or neglect, but a perpetrator cannot be identified.

Nearly three-quarters of substantiated abuse and neglect findings are classified as Category 3 conduct.

Closed Substantiated Abuse and Neglect Cases by Category for 2021

Total Closed Abuse and Neglect Cases	**2,965**
State Operated Total	**429**
Category 1	11
Category 2	81
Category 3	328
Category 4	9
Non-State Operated Total	**2,536**
Category 1	92
Category 2	519
Category 3	1,846
Category 4	79

The Justice Center makes several parties aware of the findings of an investigation. The victim or their personal representative will be issued a "letter of determination" (LOD), making them aware of the outcome of the allegations. A LOD is also issued to the director of the facility or program, the SOA that licenses or certifies the facility or program and the subject of the investigation.

Substantiated Allegations in Closed Cases* - 2021

Type	State Operated	Non-State Operated
Neglect	88.6%	88.2%
Physical Abuse	21.0%	18.9%
Deliberate Inappropriate Restraint	18.4%	10.1%
Obstruction	5.4%	4.7%
Psychological Abuse	4.2%	2.8%
Sexual Abuse	0.9%	2.7%
Other	1.4%	0.6%

*Percentages based on total cases closed. Some cases contain more than one substantiated allegation.

v. Appeals

An appeals process (called a request for amendment) is available to subjects of substantiated reports to ensure due process. Subjects have 30 days to challenge Justice Center findings. Upon receipt of an appeal request, the Justice Center reviews the investigative file, the substantiated report, the request for amendment and any additional information provided by the subject. A determination is then made as to whether there is a preponderance of evidence to support the substantiation as well as proper category assignment.

If the substantiated finding is upheld, subjects can proceed to a hearing before an Administrative Law Judge. The judge considers all the evidence presented by both the Justice Center and the subject or their legal representative and makes a recommended decision that is reviewed by the Justice Center's Executive Director. One of three outcomes is then possible:

- The Executive Director finds the Justice Center met its burden to prove the allegation and the correct category level was assigned. The substantiated finding remains against the subject in the VPCR.
- The Executive Director finds the Justice Center met its burden to prove the allegation, but the category level assigned was inappropriate. The substantiated finding remains with a new category level assigned by the Executive Director.

- The Executive Director finds the Justice Center did not meet its burden to prove the allegation. The report is unsubstantiated and the record is sealed.

In 2021, the Administrative Appeals Unit (AAU) received 700 requests for amendment, closed 988 cases; made 882 de novo determinations, and held 92 hearings.

vi. Discipline

Disciplinary or other employment actions resulting from a substantiated finding are at the discretion of the *employing provider agency* (State Oversight Agency or private provider) in accordance with established rules and collective bargaining agreements, the exception being Category 1 findings which result in placement on the Staff Exclusion List (SEL). This means in the vast majority of cases, the Justice Center is not involved in any decisions regarding the discipline of a subject. The notable exception occurs with state employees, where Justice Center attorneys work collaboratively with the State Oversight Agencies to achieve appropriate disciplinary outcomes.

Justice Center attorneys represent the State at disciplinary proceedings brought against State employees, protected under Collective Bargaining Agreements, in all cases of substantiated abuse or neglect. In 2021, 217 State employees were separated from service as a result of probationary status or disciplinary charges brought against them. In addition, the Justice Center reviewed and approved 371 Notices of Discipline, which can result in an oral or written reprimand, fine, loss of leave credits or other privileges, demotion, suspension, termination or other penalties as appropriate. Further, the Justice Center participated in 104 days of expedited hearings or agency-level mediations and 39 days of full arbitration totaling 285 cases.

Employee Action Process Completed	**# Complete Actions**
Closed Substantiated	**766**
Termination Total	217
Loss of Leave Credits or Other Privileges	103
Suspension	148
No Penalty	162
Counsel or Train (subset of No Penalty)	101
Letter of Reprimand	74
Resigned	104
Fine	61
Probation Terminated	39
Upheld at Arbitration	13

Exclusion or Other	13
Retired	31
Other Penalty	1

- **Administrative Action Reporting Mechanism**

  State Oversight Agencies require provider agencies under the jurisdiction of the Justice Center to submit information about what administrative actions have been taken with respect to subjects of substantiated allegations of abuse or neglect in non-state operated settings. The information is submitted to the Justice Center through a web application. The requirement allows State Oversight Agencies to ensure providers they license or certify are responding to substantiated allegations of abuse or neglect with appropriate corrective action. The chart on the next page indicates the type of disciplinary action taken by private providers, and the number of times that action was taken in 2021.

AARM Action	# Complete Actions
Grand Total	**4199**
Termination	1043
Counseling (Formal-Written)	859
Re-Training	822
Resignation/Retirement	264
Training	236
Counseling (Informal-verbal)	199
Suspension (30 or more days)	151
Suspension (1-14 days)	137
Staff Reassignment/Relocation	126
Letter of Reprimand	101
No Action	95
Suspension (15-30 days)	64
Additional Staff Supervision	38
Employee Assistance Referral	20
Placed on Probation	20
Demotion	18

VIII. MORTALITY REVIEWS

The *Protection of People with Special Needs Act* requires the deaths of all individuals receiving services from a residential facility or program licensed, certified, or operated by OPWDD, OMH, OASAS or OCFS to be reported to the Justice Center. In addition, the death of any individual who received services from the above facilities in the 30 days prior to their death must also be reported. Any time a death is reported to the Justice Center where there is an allegation of abuse or neglect, a separate notification is sent to both the district attorney and the medical examiner.

❖ Process of an Assessment or Investigation

The requirement to report a death is not exclusive to those that may have been caused by abuse or neglect. Instead, the death of every service recipient in these certain residential settings, regardless of the circumstances, must be reported to the Justice Center. For this reason, the agency has broken the investigations into two separate categories.

i. Executive Law § 556 Reviews

The vast majority of death reports received by the Justice Center fall under Executive Law § 556. This section of law requires administrators of residential programs licensed, operated or certified by OPWDD, OMH, OASAS and OCFS to report all deaths of residents to the Justice Center, regardless of whether the death is unusual or expected. The purpose of this reporting is twofold: to monitor and examine whether quality of care issues may have contributed to an individual's death and to make recommendations to improve future care of individuals receiving services and prevent the recurrence of similar issues.

All deaths reported under Executive Law § 556 are reviewed by investigators with program experience as well as health care professionals, including registered nurses. Through these reviews, the Justice Center can make recommendations to providers on how to improve quality of care. Letters are sent to both providers and the appropriate SOA for monitoring of recommended corrective actions.

ii. Mortality Investigations

Mandated reporters under Justice Center jurisdiction are required to report any death for which they have reasonable cause to suspect abuse, neglect or a significant incident may have been involved. Any death report potentially involving abuse or neglect follows the same investigative process as other abuse or neglect reports: classification and assignment of unique case number, investigation and determination. Medical examiners and district attorneys are notified of a death through electronic means as well as by telephone.

The Justice Center has developed a specific protocol that it follows for reviewing abuse/neglect cases where a death is involved. Initial review involves input from a supervising investigator, a criminal investigator, a lead Justice Center investigator, the regional nurse, the Assistant Special Prosecutor for the region and a representative from the Office of General Counsel. This comprehensive approach allows team members with varied backgrounds to advise on the approach for the investigation. The team is presented with information including medical and clinical history of the individual receiving services, a synopsis of the circumstances surrounding the death, involvement by local law enforcement, medical examiner or district attorney and history of any concerns regarding the program or facility.

Cases of abuse or neglect involving the death of a service recipient do not necessarily mean the abuse or neglect *caused* the death. The Justice Center evaluates causational versus corresponding links when assigning category levels of substantiated cases.

Cases of abuse or neglect with death involved are also reviewed by the Justice Center's Special Prosecutor in addition to the notifications sent to the local district attorney.

iii. Medical Review Board

The Justice Center Medical Review Board (MRB) advises on cases as needed or warranted. The Board consists of up to 15 physicians with expertise in forensic pathology, psychiatry, internal medicine and addiction medicine. In 2021, 10 cases were referred to the MRB.

The MRB is called upon for all full death reviews to give an opinion on whether the standard of care was met for the deceased. The designated primary reviewer member of the MRB for each case is given all information pertinent to the case (documents, summary reports, interviews/interrogations). The case is presented at the next regularly scheduled MRB meeting. The primary reviewer provides their expert opinion and other members of the MRB can weigh-in on the discussion.

The MRB can also consult or perform a full review for all abuse/neglect cases with death involved as needed upon request of an investigator. A consult routinely relates to a specific question while a full MRB review happens after the completion of the investigation and the investigatory question of whether abuse or neglect occurred remains. The MRB also reviews trend reports on completed mortality assessments at least annually.

IX. CONCLUSION

It is unequivocal that people with special needs are safer today than before the inception of the agency. Under the guidance of Governor Hochul and in partnership with State and private provider agencies, individuals with disabilities, family members and

advocates, the Justice Center will build upon the accomplishments detailed in this report in the year ahead. The agency continues to explore and develop new approaches to strengthen the Justice Center's ability to safeguard New York's most vulnerable citizens.

X. APPENDIX A

The Justice Center oversees facilities and provider agencies within the systems of six State Oversight Agencies (SOA):

- **Office for People with Developmental Disabilities (OPWDD)**
  - Facilities and programs operated, licensed or certified by OPWDD
- **Office of Mental Health (OMH)**
  - Facilities and programs operated, licensed or certified by OMH
- **Office of Addiction Services and Supports (OASAS)**
  - Facilities and provider agencies operated, licensed or certified by OASAS
- **Office of Children and Family Services (OCFS)**
  - Facilities and programs operated by OCFS for the youth placed in the custody of the Commissioner of OCFS
  - OCFS licensed or certified residential facilities that care for abandoned, abused, neglected, dependent children, Persons in Need of Supervision or juvenile delinquents
  - Family-type homes for adults
  - OCFS certified runaway and homeless youth programs
  - OCFS certified youth detention facilities
  - Specialized-secure detention for pre-adjudicated adolescent offenders jointly administered by designated county agency and the county sheriff
- **Department of Health (DOH)**
  - Overnight and traveling summer day camps for children with developmental disabilities under DOH jurisdiction and certain adult homes that meet census criteria for the number of beds and percentage of residents with serious mental illness.
- **State Education Department (SED)**
  - New York State School for the Blind
  - New York State School for the Deaf
  - State-supported (4201) schools which have a residential component
  - Special act school districts
  - In-state private residential schools approved by SED

XI. APPENDIX B

Justice Center Advisory Council Members

William T. Gettman — Northern Rivers Family of Services (Chair)

Norwig Debye-Saxinger — Therapeutic Communities Association

Denise A. Figueroa — Independent Living Center of the Hudson Valley

Jason Hershberger, M.D. — Brookdale University Hospital and Medical Center

Walter J. Joseph, Jr. — Children's Home of Poughkeepsie

Jeremy E. Klemanski — Helio Health

Ronald S. Lehrer — NYS Association of Boards of Visitors

Glenn Liebman — Mental Health Association in New York State

Joseph Macbeth — National Alliance for Direct Support Professionals

Thomas McAlvanah — Interagency Council of Developmental Disabilities Agencies of NY

Delores Fraser McFadden — Behavioral Momentum Applied Behavior Analysis, PC

Megan O'Connor-Hebert – Care Design NY

Kathy O'Keefe — Pilgrim Psychiatric Center

Judith A. O'Rourke — Parent

Clint Perrin — Self Advocate

Harvey B. Rosenthal — NY Association of Psychiatric Rehabilitation Services (NYAPRS)

Mary K. St. Mark — Parent Advocate and Board President, Institutes for Applied Human Dynamics

Jeffrey Savoy — Odyssey House

Euphemia Strauchn — Parent, Families on the Move